



STATE OF IDAHO
DEPARTMENT OF ADMINISTRATION
OFFICE OF INSURANCE MANAGEMENT
P.O. BOX 83720 BOISE, ID 83720-0035
(208) 332-1860 OR 1-800-531-0597

ogi@adm.state.id.us

Self Pay Reporting Form

Dental

Agency _____

Month _____

LWOP

Eligible to pay for 6 months only.

Name	Social Security No.	Date accrued leave expired	LWOP Date	Reason for LWOP	Premium paid (Including state share)
Total premium received					

Misc

Name	Social Security No.	
Total premium received		

Disability

Use only if employee has filed a disability claim

Name	Social Security No.	Date Disabled	Premium paid
Total premium received			
For OGI use only	State shares paid by Group Insurance		
	Total premium paid		